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The essential guide to health care quality

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Table of Contents

INTRODUCTION
A Letter from Margaret E. O'Kane 4

CHAPTER 1
What Is Health Care Quality? 6
Sidebar: Is There Such a Thing as Too Much Care? 9

CHAPTER 2
What Affects Health Care Quality? 10
Sidebar: How Can Consumers Drive Better Quality Care? 13
Sidebar: State Snapshots of Health Care Quality 13

CHAPTER 3
Measuring Health Care Quality 14
Sidebar: Consumers and Health Literacy 16
Sidebar: Who Is Educating Consumers About Health Care Quality? 16

CHAPTER 4
How Can the Way We Pay for Care Affect Quality? 18
Sidebar: How Does Paying for Performance Reward Quality? 19

CHAPTER 5
Reducing Medical Errors 20
Sidebar: Patient Safety Law Seeks to Promote a Culture of Safety 23
Sidebar: The 100,000 Lives Campaign 23

CHAPTER 6
Using Health Information Technology 24
Sidebar: The American Health Information Community 26
Sidebar: Physician Practice Connections 27

CHAPTER 7
Managing Chronic Illness 28
Sidebar: Medicare Health Support 29
CHAPTER 8
What Is Government's Role? 30
Sidebar: Health Care Transparency 33
Sidebar: Developing New Quality Measures 33
CHAPTER 9
What Would the Ideal Health Care System Look Like? 34

APPENDIX 1
Glossary 36
APPENDIX 2
Government Agencies and Non-Profit Organizations 38
APPENDIX 3
Key Publications and Resources 42
APPENDIX 4
Quality Initiatives/Resources 44
APPENDIX 5
References 48

A Letter from Margaret E. O'Kane

A decade ago, *"The Essential Guide to Health Care Quality"* could not have been written. Then, as now, the issues of rising medical costs and swelling numbers of uninsured Americans were a focus of our national debate. But systematic measurement of health care quality didn't exist back then; in fact, some questioned whether doing so was even possible. However, a few visionaries realized that measuring health outcomes and public reporting of the results were not just possible, but necessary next steps if America was going to address these issues.

We now know that measurement and reporting of health care quality are more than just possible. Quality measurement identifies where things are going well, shows where things need improvement and helps define how to make those improvements. Over the past 10 years, progress in health care quality has saved more than 53,000 lives through improvements in controlling high blood pressure, blood sugar levels in diabetic patients and administering beta blockers to those who have suffered heart attacks.

At the same time, there has also been a sharp increase in the number and type of quality measurement activities in the U.S. as a rising number of individuals and organizations endeavor to learn as much as they can about this important topic.

"The Essential Guide to Health Care Quality" is designed to provide policy makers and health care stakeholders a clear understanding of the issues, initiatives and organizations that are working to improve health care quality. It answers questions from 'who does what' to the philosophical questions of what a quality health care system would look like and how it would work. It also contains a glossary of terms and a list of useful resources.

Since 1990, the National Committee for Quality Assurance (NCQA) has been improving the quality of health care through measurement, transparency and accountability. We are proud to bring you this primer on health care quality.

In addition, we hope you will take the opportunity to visit our Web site, www.ncqa.org, for the latest news and information about health care quality.

Thank you for your interest in the quality of America's health care. We hope this primer is a useful reference to which you will refer frequently in the future.

Sincerely,

Margaret E. O'Kane
President, National Committee for Quality Assurance

CHAPTER 1

What Is Health Care Quality?

Every American has his or her own definition of high-quality health care. For some people, that definition revolves around whether they can go to the doctor or hospital of their choice. For others, it means access to specific types of treatment. In recent years, there has been a great deal of attention paid to defining health care quality so that we, as a nation, can work together to improve care.

In 2001, the highly regarded Institute of Medicine (IOM) of the National Academy of Sciences issued a landmark report—*Crossing the Quality Chasm: A New Health System for the 21st Century*—that called on the nation to aggressively address the dramatic deficiencies in the quality of health care delivered in the U.S. The IOM defined quality health care as "safe, effective, patient-centered, timely, efficient and equitable."[1]

The Agency for Healthcare Research and Quality (AHRQ), the federal government's leading agency charged with improving the quality, safety, efficiency and effectiveness of health care for all Americans, defines quality health care "as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."[2]

Both definitions provide us with a clear picture of good quality health care. It is based on scientific and medical evidence, it takes the specific details of a patient's life into consideration and it is aimed at improving the health and life of the patient being treated.

How good is health care quality in the United States?

While most Americans believe that the care they receive is the best that medicine and science can provide, the evidence shows a very different picture. Despite the fact that our nation spends nearly $2 trillion a year on health care, approximately 16 percent of the gross national product, research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed. Quality problems fall into three broad categories.

- **Underuse.** Many patients do not receive medically necessary care.
- **Misuse.** Each year, more than 100,000 Americans get the wrong care and are injured as a result.[3] More than 1.5 million medication errors are made each year.[4]
- **Overuse.** Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

These failures can result in serious harm to patients—even death. Fortunately, much has been learned over

the last 20 years about how to measure and improve the quality of care. Many initiatives are under way throughout the U.S. to use that knowledge to make health care consistently safer and more effective.

How often do Americans receive high-quality care?

Research indicates that quality of care in the U.S. is uneven, at best. To cite just a few examples:

- Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.[5] And all Americans are at risk of receiving poor care—regardless of where they live, how much money they have, or their race, education or health insurance.[6]
- As many as 91,000 Americans die each year because they don't receive the right evidence-based care for such chronic conditions as high blood pressure, diabetes and heart disease.[7]
- Tens of thousands of Americans die each year as a result of preventable hospital errors.[8] Nearly 90,000 people die every year, at least in part because they obtain an infection while in the hospital.[9]

What is being done to improve health care quality in the United States?

Virtually every part of the health care industry—hospitals, health plans, physicians, nursing homes, home health providers and others—is working to improve health care quality. The federal government, states, employers and consumer advocates are also focused on improving care.

Quality improvement actions include:

- Increase the number of children who are fully immunized by the age of 2 years by identifying eligible children, educating parents, sending out reminders and scheduling evening and weekend hours.
- Increase the number of women who have had a mammogram by opening clinics in communities, reminding women that they are due for a mammogram and creating incentives for getting the test done.

VARIATIONS IN HEALTH CARE QUALITY INCREASE COMPLICATIONS, LEAD TO POORER OUTCOMES AND COST MONEY

Condition	What We Found	Potentially Preventable Complications or Deaths*
Hypertension	Less than 65% received indicated care	68,000 deaths
Heart Attacks	39-55% did not receive needed medication	37,000 deaths
Pneumonia	36% of elderly received no vaccine	10,000 deaths
Colorectal Cancer	62% not screened	9,600 deaths

Source: Woolf SH, "The Need for Perspective in Evidence-Based Medicine," *Journal of the American Medical Association*, Vol. 282, 1999, pp. 2358-2365.
* Numbers are annual

- Improve screening for complications of diabetes by educating patients and doctors, sending reminders to diabetic patients who are due for a doctor's visit or test, creating posters and other educational materials to help inform patients of the care they need and eliminating language barriers to care.

Some employers, consumers, labor unions and others use quality measurement results to guide their health care purchasing decisions, including linking quality to payment. Giving comparative quality information to consumers is another key focus of some quality initiatives. Employers, government agencies and consumer groups produce report cards on health care quality to help consumers choose a health plan or provider.

Are these efforts improving care?

Several recent reports suggest at least modest improvements in health care quality:

- Based on one set of measures, the overall quality of care for Americans improved at a rate of 2.8 percent in 2005. Improvements were greatest in such key areas as diabetes, heart disease, pneumonia, nursing home care and maternal and child health care.[10]
- For the seventh straight year, quality of care increased in 2005 among health plans that report on their performance.[11] As a result, more than 53,000 lives were saved over the last eight years due to improvements in care for diabetes, high blood pressure, high cholesterol, heart attacks and other health problems.
- A broad campaign to reduce medical errors saved an estimated 122,300 lives between December 2004 and June 2006 by involving more than 3,000 hospitals in specific actions to improve patient safety.[12]
- The quality of patient care improved significantly among hospitals participating in a project to link payment with better performance. Care improved for patients who had heart attacks, pneumonia, coronary bypass surgery and hip and knee replacements.[13]

What's next?

The evidence that Americans' health care needs improvement seems to have convinced many leaders that it is time to act. The number of efforts to improve care is growing quickly. As a result, we are learning new ways to do so. The following chapters provide more details on these exciting initiatives that hold great promise.

Is There Such a Thing as Too Much Care?

There is a common perception that quality health care means more health care. But in some cases, the medical evidence is clear—we are wasting money and providing care of questionable value. Here are some examples:

- Back pain is one of the most common ailments in America, affecting over 30 million people each year. For the majority of patients, back pain is best treated with simple pain management and a gradual return to physical activity, and typically ends within 30 to 40 days. Yet the treatment offered for back pain varies widely, from physicians who work with patients to manage their pain and return them to physical activity as quickly as possible, to x-rays, CT scans and even surgery.
- A 2003 study that found that one in three patients who received antibiotics for sore throats was later found to have had a viral infection (for which the medicine did absolutely no good[14]) and the overuse of antibiotics helps build up resistance to those drugs, in individual patients and in entire communities. In addition, overuse of antibiotics costs our country more than $250 million a year.

CHAPTER 2

What Affects Health Care Quality?

Many things contribute to health care quality. By expanding our understanding of these factors, we can be more effective in our efforts to improve it.

What factors help ensure good health care quality?

- **Make the most of the best available medical research.** It's important for doctors to know the latest information about the best ways to care for their patients. But hundreds of thousands of medical research articles are published every year. For most doctors, this is simply too much information to read and digest without assistance. As a result, new findings about best practices often don't get translated into clinical practice, or take many years to do so. Despite our national investment in medical research and health care, we don't have enough evidence about what works for many diseases and conditions that affect us.
- **Make complete information about a patient's health available to doctors when they need it.** Doctors need to know about their patients' past health and medical problems, and their family's medical history as well, to provide quality care. Too often, patient information is contained in paper medical files that may be incomplete, lost, illegible or inaccessible.
- **Coordinate care among multiple doctors.** Depending on their health, patients may see many doctors. To provide the best care, there must be communication and coordination among all these health care professionals.
- **Provide comprehensive, continuous care.** People living with chronic conditions like diabetes need care on a regular, ongoing basis. If they get the right care at the right time, their overall health care costs can actually be lower. But if they don't, their health care needs can become much more serious and more expensive.
- **Pay for quality instead of volume.** Today, most doctors and hospitals are paid more money if they provide more services to patients. But more care isn't necessarily better care (see p.9). Some leaders are experimenting with linking pay to the quality of the care that is provided.
- **Engage patients in their care.** Patients' understanding of their health and the care available to them is very important to their ability to get quality care. The ability to understand and follow a doctor's advice can often make the difference between getting well or staying sick.

How can health care quality be improved?

Doctors, hospitals, insurers and others are experimenting with new approaches to improving health care quality and safety. Some of their solutions include:

- **Use computerized information technology.** Electronic health records and other information systems can help prevent medical errors and improve treatment decisions and quality and efficiency of care by helping caregivers understand what treatments work, what drugs to prescribe and what other care a patient might be receiving.
- **Expand measurement and reporting.** Most Americans receive care from providers and systems that do not measure and report on the quality of that care. Efforts are under way to expand the number and type of providers and care delivery systems that are either encouraged or required to measure and report on quality.
- **Increase care management.** People living with complex diseases usually need more than one doctor to care for them and keep them healthy. Management of care, including exchanging information and coordinating treatment between physicians, is extremely important. Today, many health plans include care management in their benefit package. Many employers contract with a separate company to help patients with chronic conditions learn how to manage and improve their health. Other companies have introduced new benefits to help people stay healthy in the first place through better diet and exercise and by other means.
- **Payment linked to quality.** Many employers believe that the best way to get quality from health care providers is to make sure that how we pay for care encourages and rewards high-quality care. A number of "pay-for-performance" initiatives are under way to test this approach. (See Chapter 4.)

How Can Consumers Drive Better Quality Care?

Consumers can actively demonstrate that they value quality. Some examples include:

- **Use public "report cards" on health care quality to select health plans, and, when possible, doctors and hospitals.** Consumers may also use quality information to make treatment decisions, such as whether to undergo a specific surgical procedure or use a certain prescription medication.
- **Understand their options. There is often more than one way to treat a medical condition.** Some methods may be equally effective but have different effects on health and quality of life. The costs of these options can also differ. By knowing all of their options, consumers can choose what is best for them.
- **Learn how to manage chronic illness better and become more involved in health care decision making.** Medicaid patients in Kentucky earn credits for extra benefits, such as eyeglasses or tobacco cessation classes, when they sign up for a disease management program.

State Snapshots of Health Care Quality

In 2006, AHRQ released a Web-based tool called State Snapshots[15] (www.qualitytools.ahrq.gov/qualityreport/2005/state/summary/intro.aspx) to help people understand the strengths, weaknesses and opportunities for improving health care quality in their states. Specifically, the 2005 State Snapshots:

- Rank each state on 15 important measures of health care quality.
- Show a state's performance relative to that of the region or nation on measures of health care quality.
- Report on quality for different types of care in each state.
- Provide downloadable data tables for each state.
- Report in depth on diabetes treatment in each state.

CHAPTER 3

Measuring Health Care Quality

In order to improve health care quality, we need to be able to measure it. The U.S. is a leader in developing reliable measures of health care quality, and more work is being done today to increase the number of measures we can use.

How do we measure quality?

One way focuses on measuring **processes of care.** For example, is a patient with diabetes getting his eyes examined when he should? Is a heart attack patient given aspirin before she leaves the hospital? Is a patient's high blood pressure being controlled by changes in habits and with the appropriate drugs? Such measures generally are derived from the best available evidence on what constitutes the "gold standard" of care for specific illnesses and health problems.

Another approach to measuring quality targets **outcomes of care**. Is a knee surgery patient walking well following physical therapy? Did a surgical patient need to be readmitted to the hospital because of a complication or infection? How many school days has an asthmatic child missed because of his condition? These types of measures examine the effects of care on patients.

A third strategy for assessing health care quality involves **the experience of patients and their family members**. Surveys ask patients about their overall satisfaction with care, the quality of their communication with their care providers and their ability to get needed care quickly. They are also asked how well their pain was managed and whether or not they were given—and understood—instructions for their ongoing care when they left the doctor's office or hospital.

What are some key tools and programs for measuring and improving quality?

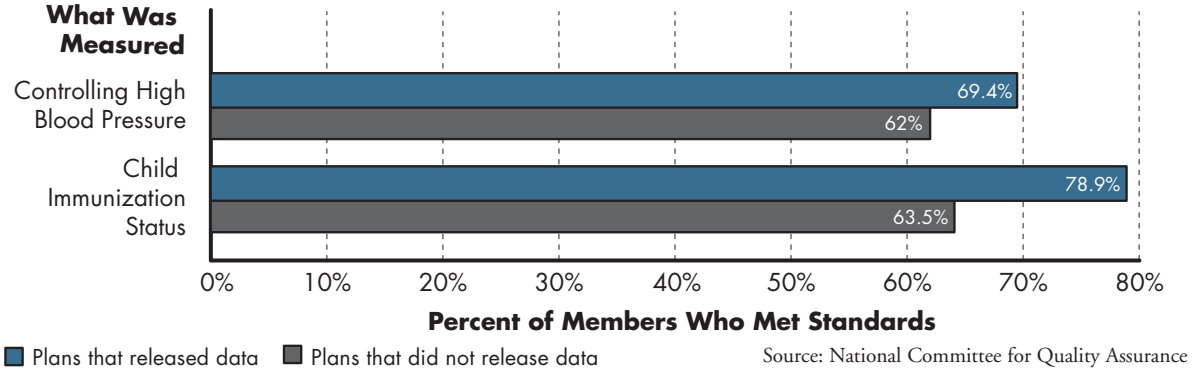
- **The Health Plan Employer Data and Information Set (HEDIS®)** is designed to help employers and consumers know how well their care follows accepted standards. Examples of HEDIS measures are the percentage of heart attack patients who are given a drug called a "beta-blocker" that helps prevent another heart attack and the percentage of women ages 52 to 69 who had an annual mammogram. Today, HEDIS is used by more than 90 percent of health plans in the United States, including those that participate in Medicare and Medicaid.
- **The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** is a group of surveys asking consumers and patients to report on their health care experiences.

- **ORYX™** is a program for measuring the performance of hospitals, nursing homes, home care agencies and mental health care providers that focuses on the processes and results of care. For example, some hospital performance measures under ORYX focus on treatment of heart attack, heart failure and pneumonia, as well as prevention of surgical infections.
- **The Medicare Health Outcomes Survey (HOS)** is used to assess the physical and mental well-being of people who are enrolled in managed care plans.
- **Nursing Home Compare** measures the quality of care in nursing homes, focusing on whether residents are in pain, whether they are under physical restraint, whether they are able to move around, whether they get a urinary tract infection and whether they become anxious or depressed.

How are quality measurements being used today to improve health care?

- **To support informed consumer choice.** Consumers can use comparative quality information (not just report cards) to help them choose a health plan, a hospital, or, in some cases, a doctor. Consumer use of quality measures to select doctors and hospitals is quite low. In 2004, only 8 percent of Americans said they used quality information to choose a hospital and only 6 percent to choose a doctor.[16] A major reason for this is that most information about health care is not written with consumers in mind. As a result, many people find the information virtually worthless.
- **To ask questions about their care.** The best way for consumers to improve the care they receive is to become more involved; to question their doctors and discuss treatment options with them.
- **To target areas that need improvement.** Hospitals, health plans and others can use the results of measurement to prevent errors and improve patient safety.
- **To find out whether care is improving.** Once a change is made to improve care, it's important to measure whether it worked.
- **To reward providers for better care.** Quality measures can tell employers and others whether they are getting what they want and reward doctors and hospitals that are doing a good job.

HEALTH PLANS THAT PUBLICLY REPORT THE QUALITY OF CARE AND SERVICE THAT MEMBERS RECEIVE PERFORM BETTER THAN PLANS THAT DO NOT



Source: National Committee for Quality Assurance

Consumers and Health Literacy

Health care is often a confusing world of technical language not easily understood by most people. Poor understanding between heath care providers and patients leads to poor quality care. A patient who can't follow her doctor's advice is unlikely to get needed care.

Arming consumers with solid information about health care quality is one of the most effective ways to improve quality. Yet nearly half of all American adults—90 million people—have a hard time understanding and using health information.[17] Because information can be technical and confusing, many people struggle to understand it. And studies have shown that people who don't understand health information will get fewer preventive health services and will be more likely to require emergency care.[18] The Institute of Medicine has called for setting new rules about how information is communicated and helping consumers learn more about their care.

Who Is Educating Consumers About Health Care Quality?

Many groups and organizations provide quality information to consumers. The Centers for Medicare and Medicaid Services (CMS) has created a Web site called Hospital Compare (www.hospitalcompare.hhs.gov/) that allows consumers to search for information on quality care at hospitals. CMS also has a Web site called Nursing Home Compare (www.medicare.gov/NHCcompare/home.asp), which does the same for nursing home care. Other consumer-oriented sites include:

- The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Quality Check (www.qualitycheck.org) allows patients to search for accredited hospitals and other health care facilities.
- The National Committee for Quality Assurance (NCQA) has created www.healthchoices.org (www.healthchoices.org) to provide information on health plan report cards and physician groups.
- HealthPages.org (www.healthpages.org) publishes consumer reviews of doctors and hospitals and provides information about different medical conditions.
- *U.S. News & World Report* publishes annual rankings of America's best health plans and best hospitals. Both are available at www.usnews.com.
- A number of states issue their own health care "report cards" for consumers. These states include California, Florida, Illinois, Iowa, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Virginia, Washington and Wisconsin.

CHAPTER 4

How Can the Way We Pay for Care Affect Quality?

The U.S. spends more than $2 trillion on health care every year, more than any other country in the world. Most health care bills are paid by private insurance companies or by government programs like Medicare and Medicaid. Americans also spend a great deal of money out of their own pockets to pay for care.

The way we pay for care has a big impact on the quality of care that we get. Most doctors and hospitals are paid a fee each time they treat a patient. As a result, our current payment systems pay more if more is done. Most of these payment systems were created in the 1980s and have not undergone significant changes since then. Government officials, insurers and employers are looking at ways to change how we pay for health care to create better incentives for high-quality care.

How does the current payment policy affect quality?

While there is no such thing as a "perfect" payment system, the traditional model in the U.S. is fee-for-service. Thus, most payments for health care relate to how many services (also known as the volume of care) are delivered. We also pay much more for care to treat an illness than we do to prevent it. As a result, there is little financial incentive to improve quality by providing only the right care.

For example, a surgeon who performs heart bypass surgeries is paid the same amount for every operation. A primary care doctor who effectively manages and monitors his diabetic patients and prevents expensive hospitalizations gets paid very little.

How can we change the way we pay for care to encourage better care?

Efforts are under way to change the way we pay for care so that it rewards quality instead of volume of care. Some insurance companies reward doctors for improving care for diabetes and other chronic conditions. Others reward higher patient satisfaction, better access to care, the use of more preventive care services and the appropriate use of emergency services. This approach, known as "pay for performance (P4P)," tries to create a system in which everyone has a reason to improve care for all patients. Health plans, medical organizations, employers and others are using payment linked to performance to improve the quality of care.

How can paying for quality change the way care is delivered?

Paying doctors for providing quality care encourages them to provide care that follows evidence and

guidelines. Some health plans reward doctors for meeting specific goals, such as:

- Reduce patient waiting times for appointments.
- Communicate well with patients about their health problems and treatment options.
- Provide regular foot and eye exams for patients with diabetes.
- Lower the number of times that people with asthma go to the emergency room.
- Make sure that patients are screened regularly for breast and colon cancer.

How will paying for quality change how hospitals deliver care?

Many health care purchasers believe that hospitals will provide better quality care if they are paid to do so. Examples of specific improvements that purchasers are seeking include:

- Reduce the number of unnecessary hospital admissions.
- Communicate better with patients about their conditions, treatment and instructions for care when they leave the hospital.
- Invest in electronic health record (EHR) systems and information technologies that can help improve care and prevent medical errors.
- Follow best practices for treating patients who are admitted for heart attack, heart failure and other problems.
- Reduce the number of patients who become infected while in the hospital.

Not all experts agree that paying for quality will work. For example, a recent study found that paying doctors to reach a fixed performance target produces little change in quality for the money spent and mainly rewards those who performed well already.[19]

How Does Paying for Performance Reward Quality?

"Pay-for-performance" (P4P) programs are gaining momentum across the U.S. In California, a group of health plans, doctors, hospitals, employers and consumers known as the Integrated Healthcare Association has paid more than $90 million in bonuses to doctors in groups that met performance targets in the first two years of the program's operation.[20] These payments have led to increases in the use of preventive care and reductions in hospitalizations, especially for patients with diabetes. Because they can earn rewards for doing so, more physicians are also adopting computerized information technology to help them improve care.[21]

Bridges to Excellence, the largest employer-sponsored P4P program in the U.S., has paid nearly $3 million in bonuses to doctors who achieve specific quality improvements in treating diabetes and heart conditions and who use information technology to better communicate with patients. Participating employers include General Electric, UPS, Procter & Gamble, Marriott, Raytheon and Bell South. Doctors are rewarded for following policies and standards that are linked to better quality and patient safety, such as participating in disease management programs and using automated prescribing systems.

Another employer-led health care quality initiative, The Leapfrog Group, is experimenting with linking payment to improvements in patient safety. The Leapfrog Group includes 170 companies and organizations that purchase health care, including General Motors, General Electric, Marriott International and Lockheed Martin, and focuses on proven safety measures. Doctors and hospitals are rewarded for using computers to reduce medication prescribing errors, referring patients for high-risk surgeries to use high-volume hospitals with better outcomes and staffing intensive care units with physicians who are certified in critical care medicine. Leapfrog says that these safety measures could save 65,000 lives and $41.5 billion in health expenditures each year.

Public programs like Medicare and Medicaid are also experimenting with new payment systems to encourage better quality care. See Chapter 8 for details.

CHAPTER 5

Reducing Medical Errors

Every year, tens of thousands of Americans are injured or die as a result of avoidable medical errors that occur in hospitals, doctors' offices, nursing homes and other health care settings. Medical errors also cost the nation anywhere from $17 billion to $29 billion every year in health costs and lost productivity.[22]

Improving patient safety is a national priority. The federal government, many states and hundreds of hospitals and health care organizations are working to make health care safer for patients in a variety of ways, including:

- Using computerized prescription ordering systems to prevent medication errors.
- Developing step-by-step care rules to ensure that proper care is provided.
- Training doctors and nurses to communicate with their patients.
- Creating new centers to collect reports on errors and near misses to help identify why they happen and how to prevent them.

What causes medical errors?

Most medical errors happen because systems aren't in place to prevent them, not because of a failure by an individual doctor or nurse. Causes of errors include:

- Poor communication among multiple doctors or members of a care team.
- Misinterpretation of a doctor's written prescription order.
- Not enough staff.
- Mislabeled blood products.
- Poor hygiene.
- Equipment failures.
- Mistaken diagnoses.
- Misuse or overuse of drugs, lab tests or other services.

What types of medical errors harm patients?

- Performing surgery on the wrong body part.
- Providing the wrong medications.
- Surgical mistakes.
- Mistaken patient identity.
- Delayed or mixed-up lab test results.
- Hospital-acquired infections.
- Unnecessary falls.

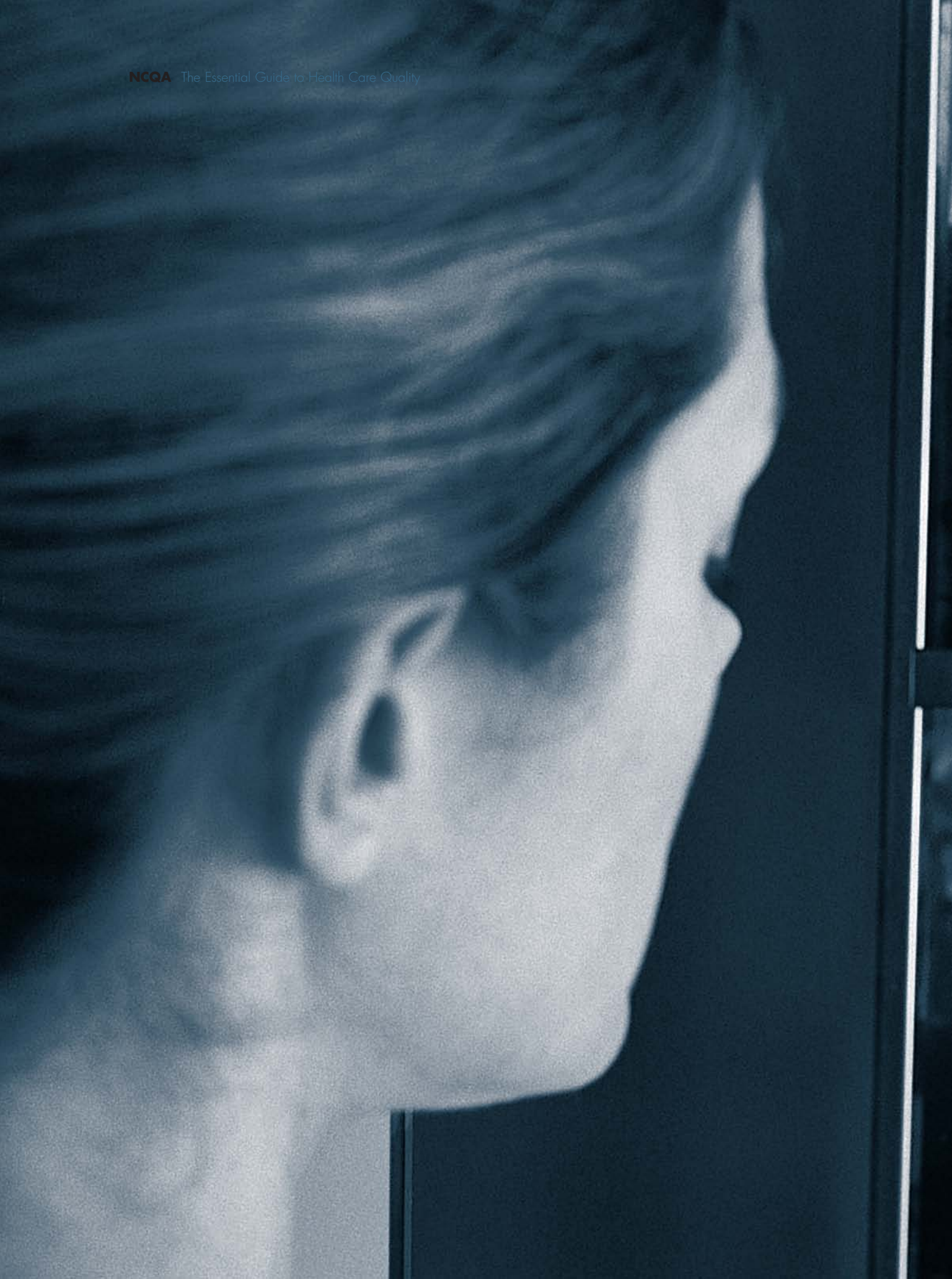
How can medical errors be reduced or eliminated?

Many hospitals are putting new rules in place that require doctors, nurses and other employees to report errors and "near misses" as soon as they happen. As simple as it sounds, hospitals are making sure doctors, nurses and others wash their hands before treating patients. Patients are given ID bracelets with a bar code to help ensure that they get the right treatment. And surgeons are marking body parts to be operated on so that the right procedure is done on the right part.

How can patients protect themselves from harm?

Patients can ask their doctors about their care and be active participants in that care. Patients who are more involved usually have better results. For example, patients should:

- Ask questions about their conditions and recommended treatments—and get clear answers from providers before they agree to care.
- Keep a list of all their medications, including non-prescription drugs, and inform doctors of medication allergies or prior adverse reactions.
- Make sure they can read their doctors' prescription orders they understand how to take the medication.
- Bring a friend or relative with them, when possible, to help them understand what's happening.
- Find out when and how to get results of tests and procedures, and what those results mean.
- Check which hospitals and doctors in their area provide the best care and can demonstrate good results.
- When facing surgery, get details up front—find out why it's necessary, what the risks are, what will happen during the operation and how recovery is likely to proceed.



Patient Safety Law Seeks to Promote a Culture of Safety

The Patient Safety and Quality Improvement Act of 2005 (P.L. 109-41) creates a voluntary system for hospitals and doctors to report medical errors and near misses. Under the law, a network of patient safety organizations collect and evaluate medical error data from participating providers and propose measures to eliminate the errors. Hospitals that participate will be protected against being sued by people who want access to the information reported to them. Although some see the law as a major step forward for improving patient safety, others question the utility of a voluntary reporting system. The new law does not preempt more stringent state laws that mandate reporting of medical errors.

The 100,000 Lives Campaign

In 2004, a national campaign was launched to save 100,000 lives by enlisting hospitals to improve patient safety and health care quality. Two years later, the campaign had exceeded its own expectations by saving an estimated 122,300 lives. Hospitals participating in this effort used six types of changes, including deploying rapid-response emergency care teams, rechecking patient medications to protect against medication errors, and using practice guidelines designed to prevent surgical-site infections.[23] More than 3,000 hospitals participated in the project.

CHAPTER 6

Using Health Information Technology

Health information technology—the use of computers to collect and share data about patients' health—is a way to harness information resources to support the delivery of safe, effective and efficient care.

Today's health care system is still overwhelmingly paper based. For example, only 17 percent of U.S. doctors use electronic medical record (EMR) systems, compared to 80 percent in the three countries (Netherlands, New Zealand and the United Kingdom) that use them the most.[24] Many efforts are under way to speed the spread of new information technology throughout the health care system.

What is health information technology?

Health information technology (health IT) uses computers, software programs, electronic devices and the Internet to store, retrieve, update and transmit information about patients' health. If used correctly, health IT can give doctors, nurses and other health professionals the information they need when they need it, so that patients get the right care at the right time.

Health IT can be used in a number of ways, including:

- Pull together all of the information about a patient into a single electronic health record (EHR).
- Computerized ordering of medications, treatments and tests.
- Provide care to people who live a long distance from doctors' offices and hospitals by connecting doctors and patients over the Internet.
- Use bedside computers to help a doctor know what treatment choices would work best for a patient.
- Share information among different hospitals and doctors caring for the same patient.
- Give patients access to their own health information.

How can health IT help patients?

For patients, health IT holds the promise of better, safer care. It can reduce medical errors by making sure that doctors and other health professionals have complete and accurate information about their patients' medical history, past and current treatments (including prescription drugs), allergies and special needs.

Quick access to information about best treatments can also improve care for patients with conditions such as diabetes, asthma and heart disease. These patients often see several doctors, and health IT can be used to manage and coordinate their care. It can help patients make choices about their health care by giving them access to personal health information and information about treatment options available to them.

Why isn't there more widespread use of health IT?

Cost is often cited as the single greatest barrier to use of health IT, especially in rural communities and among small physician practices that have less money to invest in health IT. One study estimates the cost of buying and installing an EHR system averaged $44,000, plus another $8,500 to run the system each year.[25]

This ties directly into another concern. Because there is no standard way for health information systems to exchange data, doctors and hospitals also worry about buying a system that may become obsolete if another format or technology becomes the industry standard.

What is being done to increase the use of health IT?

Numerous efforts are under way to increase the use of health IT. In 2004, President Bush set a goal for the majority of Americans to have an EHR by 2014. The President also created an Office of the National Coordinator for Health Information Technology to come up with ways to increase the use of health IT. Efforts are under way to develop a set of common standards for EHRs so that doctors and hospitals are more willing to use them.

The Medicare program began a program called Doctors' Office Quality—Information Technology (DOQ-IT) that helps provides doctors' practices understand how to use health IT to improve quality. Employers, hospitals and health plans are also working to increase the use of information technology.

How can we protect patients' privacy in an electronic information system?

Americans want to know that their personal health records are private and secure before participating in any electronic health information system.

Consumers want:

- To review who has access to their medical information.
- To be asked before their information is shared.
- To know that the identity of anyone who views their records has been carefully confirmed.
- To keep their health information off limits to their employers.[26]
- To be notified if there is a violation of their privacy.

Providers who invest in health IT are including data security systems ranging from password protection to fingerprint matching. Data networks that link different hospitals and physician practices are also working to adopt technologies and policies that will support appropriate sharing of medical information to improve care—without compromising the privacy or security of that information.

More than 100 organizations have recommended that patient records be stored locally by doctors and hospitals and only be shared electronically with other providers when appropriate and authorized by the patient.[27] The group also advocates the use of common, open Web standards to make this approach both affordable and feasible.

The American Health Information Community

In September 2005, the U.S. Department of Health and Human Services (HHS) created the American Health Information Community (AHIC) to help achieve the President's goal of making electronic health records (EHR) available to most Americans within 10 years, while ensuring the security and confidentiality of these records at the same time. In this way, patients and authorized doctors, hospitals and insurers will have access to vital medical information immediately and efficiently, helping to reduce medical errors, improve quality, lower costs and eliminate paperwork. Through AHIC, the federal government is working with private payers to develop and adopt an information architecture, standards, certification process and a method of governance for ensuring that EHRs are implemented as intended. AHIC is a federally chartered commission that provides advice and guidance to HHS.

Physician Practice Connections

Physician Practice Connections (PPC) is a program created by the National Committee for Quality Assurance (NCQA) that recognizes doctors' practices that use IT effectively to improve patient care. Doctors who make good use of information systems are better able to:

- Monitor their patients' medical histories.
- Work with their patients over time.
- Follow up with patients and other health care professionals who treat them.
- Take advantage of the best available, evidence-based care.
- Help patients manage their care better.
- Avoid medical errors.

Meeting PPC standards means that doctors have connections—to their patients, to information, to other health care professionals and to evidence. Standards cover a number of areas, including:

- Using systems to track patients, their conditions and their treatments.
- Managing patient care over time.
- Using electronic prescribing tools.
- Tracking and following up lab and imaging tests and referrals.

CHAPTER 7

Managing Chronic Illness

Some 90 million Americans suffer from chronic health conditions—including asthma, diabetes, heart disease, high blood pressure and arthritis—and their numbers are growing. According to the Centers for Disease Control and Prevention (CDC), chronic ailments account for 7 out of every 10 deaths and 70 percent of total health care costs. Chronic disease is now widely viewed as one of our nation's most pressing health problems. Today, many experts agree that providing chronically ill patients with quality care requires adopting a relatively new approach known as "disease management."

What is disease management?

Disease management seeks to improve the health and quality of life of people living with chronic illnesses. By identifying people early and working to keep them healthy, disease management programs help to reduce health care spending and keep people out of the hospital. Good disease management includes:

- Identifying patients in need of disease management (for example, all health plan members with diabetes).
- Screening patients to help diagnose conditions and begin management early.
- Using care teams to help make sure care is coordinated.
- Educating patients about their condition and how to manage their care.
- Regularly evaluating patient outcomes and symptom management.
- Routine reporting, feedback and communication between the health care team and the patient.[26]

Today, the most sophisticated disease management programs make use of new techniques—some high-tech, some more traditional—to monitor patient symptoms. Such techniques include regular telephone calls with patients, interactive Web sites where patients record the results of their home tests, and, in some cases, special devices installed in patients' homes that can automatically trigger an alert in the event of an unusual weight gain or changes in blood pressure.[29]

Who provides disease management?

Increasingly, employers are making disease management programs available to their employees, either through health plans or in separate programs. In 2003, 58 percent of employer-sponsored health plans offered disease management programs, compared with 41 percent in 2002.[30]

What are the benefits of disease management?

Disease management can save lives, reduce patient suffering and lower medical costs. For example, if they get the right care at the right time, people with diabetes can lead normal and productive lives. But if the disease is left unmanaged, a person with diabetes may experience spikes in blood-sugar levels that result in repeated emergency department visits and hospitalizations. Unmanaged diabetes can lead to blindness, amputation, kidney disease and death.[31]

The best disease management programs can reduce health care costs and workplace absenteeism. They can also reduce disability claims and worker compensation injuries, while improving workers' productivity and morale.[32]

From a patient's point of view, disease management means more regular contact with his health care team and specific directions on the medicines he needs to take, diets he should follow and lifestyle changes he should make to keep his chronic condition from causing pain or disrupting his life. For example, a patient with asthma would receive instruction to ensure that she takes her medicines properly, understands when and how to use her inhalers and knows how to monitor symptoms of an impending attack.

What does the evidence say about the effectiveness of disease management?

Evidence is mixed. Some research has shown that disease management for patients with diabetes can improve quality of care and significantly lower costs.[33] Other research has found that disease management can keep patients with congestive heart disease and chronic lung disease from being readmitted to the hospital.

Not all programs have been shown to improve quality and lower costs. For example, a recent research review[34] suggests that certain programs—for heart failure and asthma—work best if they target only patients who have moderate to severe symptoms for these conditions, rather than all patients who have these conditions.

What are the barriers to adopting disease management?

Given the increase in the use of disease management programs by employers, barriers to adoption appear to be diminishing. But debate about the "business case" for disease management continues. Many employers and other health care purchasers and payers want to know that disease management programs will help lower their costs before investing in them.[35]

Medicare Health Support

Chronic conditions are a leading cause of illness, disability and death among Medicare patients, and account for a large share of Medicare spending. Medicare is studying the effects of disease management on people over 65, particularly for those with diabetes or heart disease. Congress passed a law in 2003 that established pilot studies to test the benefits of disease management. Positive results from these initiatives could lead to more disease management, not only for Medicare consumers but also for consumers enrolled in employer-sponsored health plans. This program—known as Medicare Health Support—aims to improve quality of life for consumers and provide savings to Medicare by better managing and coordinating care of chronic conditions.

CHAPTER 8

What Is Government's Role?

The government plays a key role in ensuring health care quality in the United States. As both purchasers and regulators of health care, state and federal governments—through Medicare, the AHRQ, the Veterans Health Administration, state health departments and other agencies—are very involved in activities to measure, report on and improve the quality of health care.

States, and to a lesser extent, the federal government, set rules that health plans, doctors and hospitals must obey in order to participate in government programs like Medicare and Medicaid. They also set requirements for licensure that include training and education. While each state has its own rules, there are key similarities, including rules on access to care, confidentiality of information, credentialing of doctors and other health care professionals, patients' rights to appeal decisions and quality improvement efforts.

How does Medicare monitor health care quality?

As the largest purchaser of health care in the United States, Medicare has a critical stake in fostering and ensuring efforts to provide high-quality care for the 43 million Americans who depend on the program. The Centers for Medicare & Medicaid Services (CMS), which oversees the $345 billion Medicare program, has a broad agenda to make care "safe, effective, efficient, patient-centered, timely and equitable" through what it calls a "quality roadmap." Goals and activities include:

- Measure quality.
- Set performance standards.
- Educate consumers through public reporting of quality information on hospitals, doctors and health plans.
- Link payment to quality, to encourage doctors and hospitals to improve the care they provide.
- Assist and train doctors and other health care professionals to improve their care.
- Drive adoption of health information technology.
- Urge state Medicaid programs to adopt quality-based payment strategies.

How is the Medicare program working to improve health care quality?

- Requiring or encouraging most health care providers to measure and report on the quality of the care delivered to patients. Some of this information is posted on a Web site—www.medicare.gov—to allow the public to see and use it.

- Experimenting with new ways to link how Medicare pays for care with the quality of the care delivered. These pay for performance efforts may become a regular part of Medicare in the future.
- Medicare quality improvement organizations (QIO) work with hospitals, nursing homes, home health agencies and doctors to spread best practices, reduce medical errors and solve problems of poor quality.
- Working with organizations in the private sector to push the development of new measures of health care quality.

How do states improve health care quality?

Many states measure and monitor performance, make information on quality performance available to consumers, reward superior performance and use quality information to guide decisions. State Medicaid programs have also been active in efforts to improve quality. Some of these initiatives include:

- Publicly report the number of patients who become infected while in the hospital or because of other health care services they receive.
- Link payment with quality for health plans or physicians.
- Provide information technology and training.
- Encourage people with medical conditions to enroll in disease management programs.
- Require hospitals, physicians and other health care providers to collect data on quality of care.

How does the government help consumers identify and choose high-quality providers?

Several government initiatives support developing and reporting comparative information on health care quality and pricing for consumers. These activities include:

- Make Medicare pricing information available on line and allow consumers to evaluate key aspects of their health care options at hospitals, nursing homes and home health agencies.
- Work with private and public partners to provide comprehensive and effective measures of quality and cost.
- Support pilot programs to model the most effective ways to empower patients with personalized information on quality and pricing of services.

How has the Department of Veterans Affairs improved health care quality?

As the country's largest health care provider, the Department of Veterans Affairs (VA) is viewed as a leader in improving the quality of health care for patients who use VA facilities. Since the early 1990s, the VA has operated a quality improvement program that is now a national model. Veterans who use VA health facilities are significantly more likely than other patients—including those with private insurance—to get quality care. In general, VA patients receive consistently better care across the board, including screening, diagnosis, treatment and follow-up.[36] Some reasons for this are:

- The VA has a sophisticated EMR system that allows instant communication among providers across the country and reminds providers about patients' medical needs.
- Hospital and regional network managers are accountable for providing preventive care and managing chronic conditions.
- Monitoring systems measure performance among all VA health care providers.

Health Care Transparency

On August 22, 2006, President Bush signed an Executive Order to help increase the transparency of America's health care system. According to the President, "To spend their health care dollars wisely, Americans need to know their options in advance, know the quality of doctors and hospitals in their area, and know what procedures will cost. When Americans buy new cars, they have access to consumer research on safety, reliability, price, and performance—and they should be able to expect the same when they purchase health care." His Executive Order directs Federal agencies that administer or sponsor federal health insurance programs to:

- **Increase transparency in pricing.** Agencies must share information with patients about prices paid to health care providers for procedures.
- **Increase transparency in quality.** Agencies must share information with patients on the quality of services provided by doctors, hospitals, and other health care providers.
- **Encourage adoption of health IT standards.** Agencies should use improved health IT systems to facilitate the rapid exchange of health information.
- **Provide options that promote quality and efficiency in health care.** Federal agencies should develop and identify approaches that facilitate high quality and efficient care.

Developing New Quality Measures

A number of efforts are underway to spur the development of new health care quality measures. Many of these initiatives focus on developing measures of doctors and hospitals and other direct providers of health care services. These include:

- **AQA (formerly the Ambulatory Quality Alliance)** is a collaborative of physicians, consumers, purchasers, health insurance plans and others designed to improve health care quality and patient safety through a strategy for measuring performance at the physician or group level; collecting and aggregating data in the least burdensome way; and reporting meaningful information to consumers, physicians and other stakeholders to inform choices and improve outcomes.[37]
- **Hospital Quality Alliance (HQA)** is a public-private collaborative to improve the quality of care provided in hospitals by measuring and publicly reporting on that care.[38]
- **Pharmacy Quality Alliance (PQA)** is an initiative involving interested organizations and stakeholders seeking to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for measuring performance at the pharmacy and pharmacist-levels.[39]

CHAPTER 9

What Would the Ideal Health Care System Look Like?

The U.S. health care system is still far from what it could be in terms of quality, but a number of major initiatives are under way to harness that potential. Once that goal is achieved, Americans will experience everyday health care much differently.

What are the key elements of an 'ideal' health care system?

The ideal health care system improves how it meets patients' needs. First and foremost, it must cover all Americans. Second, it must be affordable. It must build on the elements defined by the IOM. Care must be:

- **Safe.** Patients must not be injured as a result of care.
- **Effective.** Care must be based on the best available scientific evidence and should benefit the patients who receive it.
- **Patient centered.** Health care professionals must treat patients with respect to their individual preferences, needs and values, which should guide all clinical decisions.
- **Timely.** Care must not be delayed; patients should get the care they need when they need it.
- **Efficient.** Care must not be wasteful or duplicative.
- **Equitable.** Health care services must be of consistently high quality and must not vary among patients because of gender, ethnicity, where they live and economic status.

Donald M. Berwick, MD, MPP, President and CEO of the nonprofit Institute for Healthcare Improvement (IHI), puts it a slightly different way. The ideal health care system, he says, must be fully accessible—open "24/7/365"—grounded in science, focused on patients and their needs and without secrets. "Health care should be confidential," Berwick writes, "but the health care system is not entitled to secrecy."[40]

How would consumers experience care in the ideal system?

Many experts agree that consumers would be actively involved in their own health care decision making, working in partnership with their doctors and other health care professionals. They would also see evidence of teamwork among the doctors, nurses and other health care professionals who manage and provide their care. Lucian L. Leape, MD, a professor at Harvard University and an expert on patient safety, says that consumers would also see a difference in safety because health care professions would have "almost an obsession about safety." Examples of safe practices

include warnings, checklists, double-check and repeated communications to protect against medication errors and other potential problems. Finally, Leape says, consumers "would have complete confidence that everyone was treating them openly and honestly and keeping them completely informed."[41]

How would public health improve?

In the ideal health care system, public health would improve dramatically, in a number of ways.

- All Americans would have affordable access to high-quality care when they need it.
- Patients would stay healthier longer because they would receive more preventive care, as well as disease management for chronic conditions.
- Patients would be safer because the incidence of medical errors would be greatly reduced.
- When sick or injured, patients would recover faster because care would be more effective.

What is being done to achieve the ideal health care system?

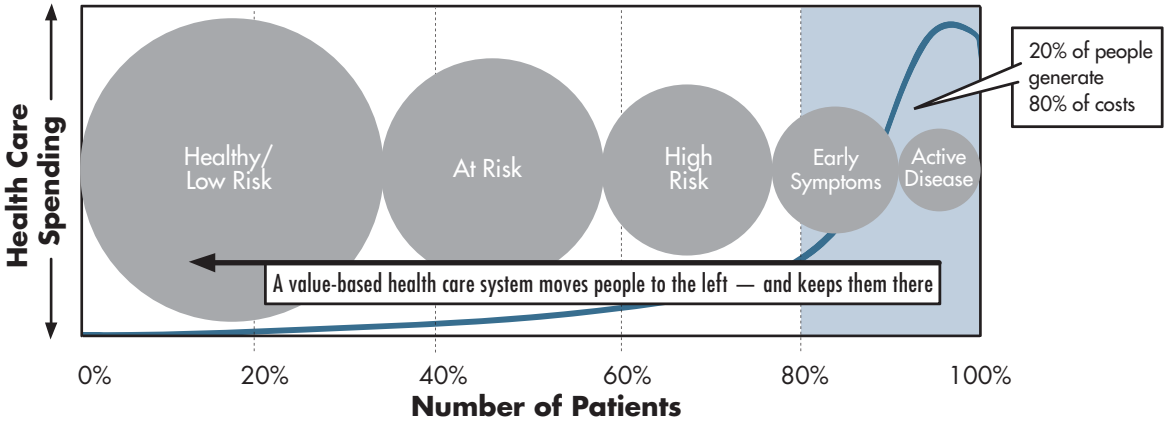
Virtually all sectors of the health care system—doctors, hospitals, patient advocates, insurers, employers and government agencies—are involved in activities to improve health care quality. These range from the internal quality improvement efforts of hospitals, health plans and doctors' offices to address specific areas of clinical care, to pay-for-performance initiatives led primarily by employers to reward quality care, to a variety of health care "report card" activities aimed at helping consumers recognize and select quality providers and health plans.

Although there is no central coordinating force behind these activities, consensus appears to be building around several key concepts for improving health care quality across the board.

- The need to coordinate care better.
- The need to translate the best available medical evidence into easily accessible practice guidelines for doctors.
- The need to invest in new information technologies that will help reduce medical errors, track the results of care and make important patient information available to doctors when they need it.
- The need to reward quality of care—not quantity.

Despite the challenges ahead, there is no question that improvements are under way. The ideal health care system is a work in progress.

HEALTH CARE SPENDING COMPARED TO RISK LEVEL



Source: HealthPartners

APPENDIX 1

Glossary

Accreditation: A "seal of approval" presented to a hospital, health plan or other organization for meeting a specific set of criteria or standards. Accreditation is viewed as a symbol of quality. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) are the most well-known health care accreditation organizations.

Benchmark: In health care, a way for hospitals and doctors to analyze quality data, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

Chronic disease: A disease that is long-lasting or recurrent and which can become a non-life threatening condition with proper disease management. Examples include diabetes, asthma, heart disease, kidney disease and chronic lung disease.

Computerized prescription order entry (CPOE): A software system that allows doctors to transmit their directions for patient care electronically to other medical staff. Done properly, CPOE speeds treatment and reduces human error related to handwriting or transcription.

Consumer-directed care: A form of health insurance that combines a high-deductible health plan with a tax-favored health savings account to cover out-of-pocket expenses.

Disease management: An approach designed to improve the health and quality of life for people with chronic illnesses by keeping their conditions from getting worse.

Disparities: Most often used to describe differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender and other factors that do not include socioeconomic status or insurance coverage. Understanding and eliminating the causes of health disparities is an ongoing effort of many groups and organizations.

Electronic health record (EHR): A computerized medical file that contains the history of a patient's medical care.

Evidence-based care or evidence-based medicine: Patient care that combines the expertise of health practitioners with the best available research evidence to ensure quality, effectiveness and safety.

Health information exchange (HIE): A computer-based network that allows sharing of patient information across hospitals, doctors and other health care institutions in a city, state or region. More than 100 state and regional HIE projects are under way across the country.

Health information technology: The use of computers, software programs, electronic devices and the Internet to store, retrieve, update and transmit information about patients' health.

Health Plan Employer Data and Information Set (HEDIS): A set of health care quality measures designed to help purchasers and consumers determine how well health plans follow accepted care standards for prevention and treatment. Formerly known as the Health Plan Employer Data Information Set.

Medical error: A mistake that harms a patient. Adverse drug events, hospital-acquired infections and wrong-site surgeries are examples of preventable medical errors.

Medical record: A paper or electronic history of a patient's medical care that includes information about past illnesses, injuries, allergies, medications, vaccinations and treatment.

"Near miss": A mistake that almost happens but is avoided. Many patient-safety advocates urge hospitals and doctors to track their near misses so that they can identify and implement processes that will make care safer.

Patient registry: A patient database maintained by a hospital, doctors' practice or health plan that allows providers to identify their patients according to disease, demographic characteristics and other factors. Patient registries can help providers better coordinate care for their patients, monitor treatment and progress and improve overall quality of care.

Patient-centered care: Care that considers patients' cultural traditions, their personal preferences and values, their family situations and their lifestyles. Responsibility for important aspects of self-care and monitoring is put in patients' hands—along with the tools and support they need. Patient centered care also ensures that transitions between different health care providers and care settings are coordinated and efficient. When care is patient centered, unneeded and unwanted services can be reduced.

Pay-for-performance (P4P): A method for paying hospitals and physicians based on their demonstrated achievements in meeting specific health care quality objectives. The idea is to reward providers for the quality—not the quantity—of care they deliver.

Performance measures: Sets of established standards against which health care performance is measured. Performance measures are now widely accepted as a method for guiding informed decision making as a strong impetus for improvement.

Practice guideline: A specific set of care recommendations designed to help health care professionals and patients make decisions about screening for preventing or treating a health condition. Practice guidelines generally are developed by reviewing the best available medical evidence, or, where such evidence is lacking, through an expert consensus process. Sometimes the two methods are combined.

Sentinel event: Any unexpected event in a health care setting that causes death or serious injury to a patient and is not related to the natural course of the patient's illness.

Telemedicine: Remote medical care provided by doctors, nurses and other health care professionals for a patient who is in an isolated area or is unable to travel.

Value purchasing: A broad strategy used by some large employers to get more value for their health care dollars by demanding that health care providers meet certain quality objectives or supply data documenting their use of best practices and quality treatment outcomes.

APPENDIX 2

Government Agencies and Non-Profit Organizations

Government Agencies

Agency for Healthcare Research and Quality (AHRQ): The federal agency charged with improving the quality, safety, efficiency and effectiveness of health care in the U.S. by supporting important new health services research and promoting evidence-based decision-making. **www.ahrq.gov**

Centers for Disease Control and Prevention (CDC): Leads the federal government's public health efforts to prevent and control infectious and chronic diseases, injuries, workplace hazards, disabilities and environmental health threats. CDC conducts research and investigations, applies research and findings to improve public health and responds to health emergencies. **www.cdc.gov**

Centers for Medicare & Medicaid Services (CMS): Oversees the federal Medicare program for the elderly, the federal-state Medicaid program for the poor and disable and the federal-state Children's Health Insurance Program. CMS' goals include protecting and improving beneficiary health and satisfaction, fostering high-quality care and providing leadership to improve health and health care. **www.cms.hhs.gov**

Department of Veterans Affairs (VA): Considered a leader in health care quality, it oversees the country's largest health care system, with a nationwide network of hospitals, outpatient clinics, and spinal cord injury centers that treat American veterans. This also makes VA the nation's largest research laboratory for testing research innovations and lessons in everyday health care. **www.va.gov**

National Center for Health Statistics (NCHS): Part of the CDC, it is the nation's principle health statistics agency, providing data to identify and address health issues. NCHS compiles statistical information to help guide public health and health policy decisions. **www.cdc.gov/nchs**

Office of the National Coordinator for Health Information Technology (ONC): Provides leadership for the development and nationwide implementation of an interoperable health information technology system to improve health care quality and efficiency. **www.hhs.gov/healthit**

Non-Profit Organizations

American Board of Internal Medicine Foundation (ABIM): An organization focused on medical professionalism, physician leadership, science-based medicine and quality health care. **www.abimfoundation.org**

American Health Information Community: A federally chartered commission that provides input and recommendations to the U.S. Department of Health and Human Services (HHS) on how to make health records digital and interoperable and ensure the privacy and security of those records. **www.hhs.gov/healthit/ahic.html**

American Health Quality Association (AHQA): Represents quality improvement organizations (QIO) and professionals working to improve the quality of health care in the U.S. QIOs are independent, largely non-profit health care organizations under contract with Medicare to work in communities in every state to promote health care quality. **www.ahqa.org**

American Hospital Association (AHA): The national organization that represents and serves all types of hospitals, health care networks and their patients and communities. Close to 4,800 institutional and 33,000 personal members belong to AHA. **www.aha.org**

American Medical Association (AMA): The nation's largest physician group, it advocates on issues concerning national health, including patient safety and health care quality. **www.ama-assn.org**

eHealth Initiative: Independent, non-profit affiliated organizations whose missions to drive improvement in the quality, safety and efficiency of health care through information and information technology. Both organizations focusing on bringing together hospitals, other health care organizations, doctors, consumers, employers, health plans, health information technology experts, manufacturers, public heath agencies, researchers and others to identify and take specific actions that will advance the use of interoperable health information technology. **www.ehealthinitiative.org**

The Commonwealth Fund: A private foundation focused on promoting better access to health care services, improved health care quality and greater health care efficiency, particularly for society's most vulnerable members, including low-income people, the uninsured, minority Americans, young children and elderly adults. The Fund supports independent research on health care issues and makes grants to improve health care practice and policy. **www.cmwf.org**.

The California Healthcare Foundation (CHCF): An independent philanthropy committed to improving the way health care is delivered and financed in California, and to helping consumers make informed health care and coverage decisions. CHCF's goal is to ensure that all Californians have access to affordable, quality health care. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders and funds development of programs and models aimed at improving the health care delivery and financing systems. **www.chcf.org**

Foundation for Healthcare Quality: An organization that supports a number of programs in performance measurement, patient safety, information technology, cross-cultural health and health data surveillance and analysis. **www.qualityhealth.org**

Institute for Healthcare Improvement (IHI): An organization dedicated to improving health care throughout the world. IHI offers conferences, training, networking and collaborative learning opportunities focused on quality improvement. It organized the 100,000 Lives Campaign and is the National Program Office for the Robert Wood Johnson Foundation's (RWJF) Pursuing Perfection program, and partnered with RWJF in the Transforming Care at the Bedside initiative. **www.ihi.org/ihi**

Institute of Medicine (IOM): Of the National Academies for Science, provides evidence-based analysis and independent guidance on matters of health and science policy to policymakers, professionals, leaders in every sector of society and the public at large. **www.iom.edu**

The Integrated Healthcare Association (IHA): A health care leadership group in California that includes health plans, doctors' groups, hospitals and health care systems, plus purchaser, pharmaceutical, technology, consumer and research representatives. IHA is dedicated to making improvements in health care services for Californians through collaboration, and is particularly active in a pay-for-performance initiative. **www.iha.org**

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): The primary accrediting body for hospitals and hospital systems, nursing homes and other health care facilities. JCAHO accreditation focuses on such areas as patient safety, health care outcomes, patient assessment and care, patients' rights, organizational leadership and information management. **www.jcaho.org**

The Markle Foundation: Administers a health program whose goal is to support the use of information technology to improve health and health care. **www.markle.org**

Medical Group Management Association (MGMA): A professional membership organization that serves doctors' practices of all sizes, as well as other, related health care organizations. Its core purpose is to continually improve the performance of medical group practice professionals. **www.mgma.com**

National Association for Healthcare Quality (NAHQ): Promotes the continuous improvement of quality in health care by providing educational and development opportunities for professionals at all management levels and within all health care settings. **www.nahq.org**

National Business Coalition on Health (NBCH): A national, non-profit, membership organization of employer-based health coalitions. NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. **www.nbch.org**

National Business Group on Health (NBGH): Representing 245 mostly large employers, it is the nation's only non-profit organization devoted exclusively to finding innovative solutions to large employers' most important health care challenges. The Business Group identifies and shares best practices in health benefits, disability, health and productivity, related paid time off and work/life balance issues. **www.wbgh.org**

National Committee for Quality Assurance (NCQA): The leading accrediting organization for health plans. NCQA reviews evaluate access to service, provider qualifications, member health status, recovery from illness and ability to manage chronic illnesses. NCQA also maintains and updates Health Plan Employer Data and Information Set (HEDIS). **www.ncqa.org**

National Patient Safety Foundation (NPSF): Dedicated to improving patient safety and reducing medical errors through leadership, research support and education. Partners include health care practitioners, institutional providers, health product providers, health product manufacturers, researchers, legal advisors, patient/consumer advocates, regulators and policy makers. **www.npsf.org**

National Quality Forum (NQF): A membership organization created to develop and implement a national strategy for health care quality measurement and reporting. Established as a public-private partnership, the NQF has broad participation from all parts of the health care system, including national, state, regional and local groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, supporting industries

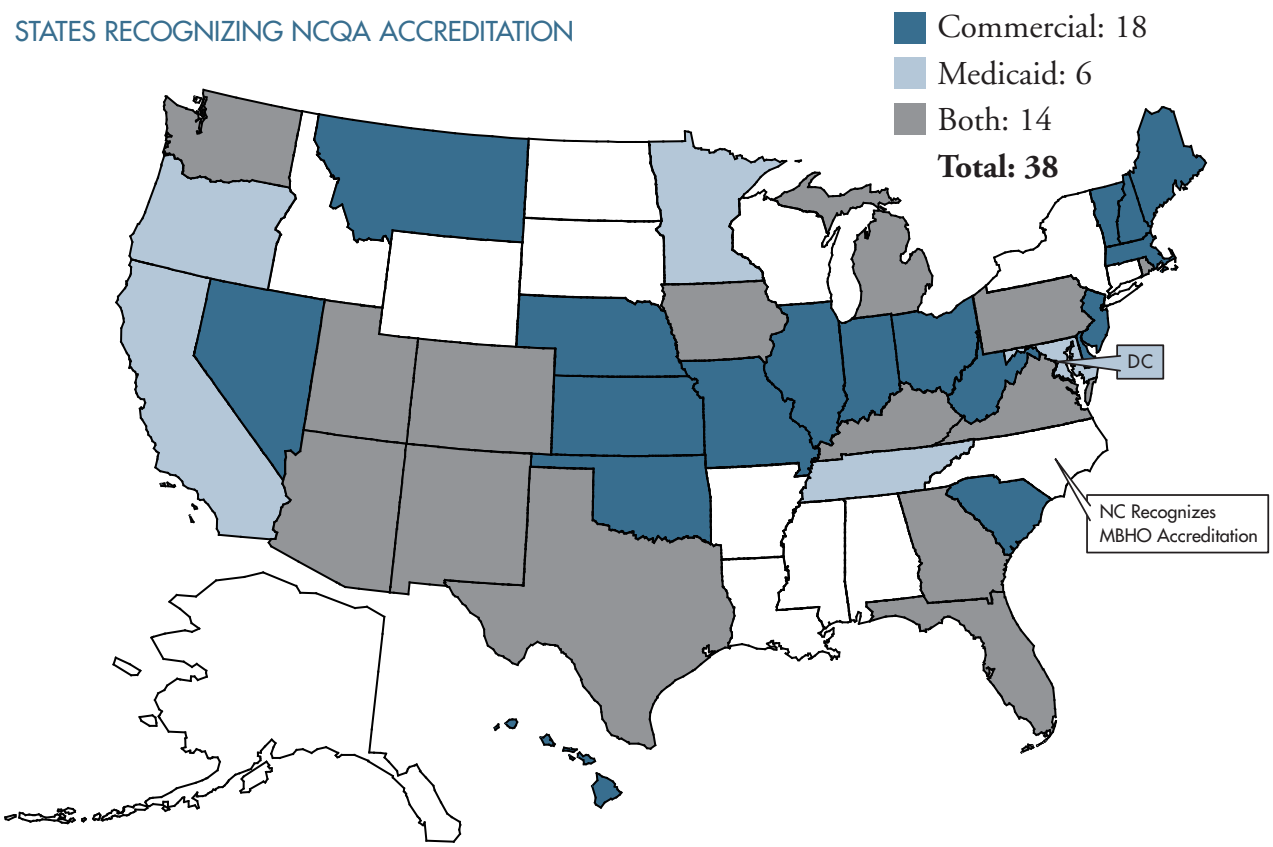
and organizations involved in health care research or quality improvement. **www.qualityforum.org**

RAND Corporation: A research and analysis institution that supports policy and decision making. In the health care area, RAND has conducted a number of major national studies on health care quality. **www.rand.org**

The Robert Wood Johnson Foundation (RWJF): The nation's largest philanthropy dedicated to improving the health and health care of all Americans. Health care quality is one of the Foundation's key areas of interest. **ww.rwjf.org**

URAC: An independent organization that promotes health care quality through accreditation and certification programs for case management, disease management, utilization management, provider credentialing and other areas. **www.urac.org**

STATES RECOGNIZING NCQA ACCREDITATION



APPENDIX 3

Key Publications and Resources

Agency for Healthcare Research and Quality

www.ahrq.gov

- *Understanding health care quality.* www.ahrq.gov /consumer/guidetoq/guidetoq4.htm.
- *2005 National healthcare quality report.* www.qualitytools.ahrq.gov/qualityreport/2005/browse /browse.aspx.
- *State Snapshots from the 2005 National healthcare quality report.* www.qualitytools.ahrq.gov qualtiyreport/2005/state.

Alliance for Health Reform

www.allhealth.org/issues.asp?wi=13

- *Rewarding quality performance: The multidisciplinary approach (Briefing).* www.allhealth.org/briefing_detail.asp?bi=78.
- 2006. *Pay-for-performance: A promising start.* Washington D.C.: Alliance for Health Reform. www.allhealth.org/BriefingMaterials /Pay-for-performance-Feb2006-162.pdf.

The Commonwealth Fund

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National Committee for Quality Assurance

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U.S. News & World Report

www.usnews.com

- *U.S. News & World Report* publishes annual rankings of American's best health plans and best hospitals. Both are available year round at: www.usnews.com.

APPENDIX 4

Quality Initiatives/Resources

100,000 Lives Campaign

www.ihi.org/IHI/Programs/Campaign/

An initiative of the Institute for Healthcare Improvement (IHI) that has engaged more than 3,000 hospitals to improve patient safety through specific practices, such as the use of rapid-response emergency care teams and checklists to prevent surgical-site infections.

Ambulatory Care Quality Alliance (AQA)

www.aqaalliance.org

A broad-based national coalition of more than 125 organizations that seeks to improve health care quality by measuring, reporting and improving performance at the physician level. Member organizations represent doctors, consumers, employers, government, health insurance plans and accrediting and quality organizations.

Bridges to Excellence (BTE)

www.bridgestoexcellence.org

A multi-state, multi-employer coalition that recognizes and financially rewards high-quality health care providers. The largest employer-sponsored pay-for-performance program in the U.S., BTE has paid close to $3 million in bonuses to doctors who have achieved specific quality improvements.

Connecting for Health

www.markle.org

Established by the Markle Foundation and supported by the Robert Wood Johnson Foundation, Connecting for Health is a public-private initiative to promote the private and secure exchange of electronic patient information. In 2006, Connecting for Health released the Common Framework, a set of technical and policy recommendations designed to achieve ensure health information privacy and security.

Department of Veterans Affairs (VA) Quality Enhancement Research Initiative (QUERI)

www.hsrd.research.va.gov/queri

Translates research discoveries and innovations into better patient care and systems improvements. QUERI focuses on 10 diseases or conditions that affect veterans: colorectal cancer, diabetes, HIV/AIDS, ischemic heart disease, mental health, spinal cord injury, stroke, substance use disorders, chronic heart failure and polytrauma.

Diabetes Physician Recognition Program (DPRP)

www.ncqa.org/dprp

Cosponsored by the American Diabetes Association and the National Committee for Quality Assurance (NCQA), DPRP assesses doctors' performance on measures of care for adults and for children.

Doctor's Office Quality Information Technology (DOQ-IT)

www.qualitynet.org/dcs/ContentServer?cid=1143577170595&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page

The Centers for Medicare & Medicaid Services (CMS) established the Doctor's Office Quality Information Technology (DOQ-IT) project as a three-year, national quality improvement initiative to help doctors purchase and adopt electronic health record systems in their practices, thereby improving the quality and safety of care provided under Medicare.

Heart Stroke Physician Recognition Program (HSRP)

www.ncqa.org/hsrp

The American Heart Association/American Stroke Association (AHA/ASA) and NCQA created this program to recognize the quality of care provided by doctors for people with cardiovascular disease or who have had a stroke.

Hospital Compare

www.hospitalcompare.hhs.gov

A Web-based consumer information initiative launched by the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Alliance (HQA). The Hospital Compare Web site allows consumers to search for information on how often hospitals provide good care for heart attacks, heart failure, pneumonia and surgery. In this way, consumers can make informed decisions about where to go for the best care.

Hospital Quality Alliance (HQA)

www.aha.org/aha_app/issues/HQA/index.jsp

A voluntary reporting initiative of the American Hospital Association (AHA) on hospital quality in selected clinical topics. The HQA Web site contains the latest data and resources available to make hospital quality information publicly available, and to improve the care that hospitals provide.

The Leapfrog Group

www.leapfroggroup.org

An employer-led health care quality initiative experimenting with ways to link payment with improvements in patient safety. Areas of patient safety focus include using computers to reduce medication prescription errors, referring patients for high-risk surgeries to hospitals with better outcomes and staffing intensive care units with physicians who are certified in critical care medicine.

Massachusetts Health Quality Partners (MHQP)

www.mhqp.org

A coalition of doctors, hospitals, health plans, purchasers, consumers and government agencies working together to improve the quality of health care services in Massachusetts. MHQP seeks to help doctors improve the quality of care they provide and help consumers make informed medical decisions.

Medicare Quality Improvement Organization (QIO) Program

www.ahqa.org

Represents the federal government's single largest investment in improving health care quality. This nationwide program provides technical support, mentoring and education to improve health care quality in communities in every state. The program is operated by 40 quality improvement organizations, independent, largely non-profit health care organizations under contract with Medicare.

National Quality Measures Clearinghouse™ (NQMC)

www.qualitymeasures.ahrq.gov

A public repository for evidence-based quality measures and measure sets, sponsored by the Agency for Healthcare Research and Quality (AHRQ) and the U.S. Department of Health and Human Services.

Pharmacy Quality Alliance (PQA)

www.pqaalliance.org

Seeks to improve health care quality and patient safety by measuring performance at the pharmacy and pharmacist levels; collecting data in the least burdensome way; and reporting meaningful information to consumers, pharmacists, employers, health insurance plans and other health care decision makers to help make informed choices, improve outcomes and stimulate the development of new payment models.

Physician Consortium for Performance Improvement® (Consortium)

www.ama-assn.org/ama/pub/category/2946.html

The American Medical Association (AMA) convened the Physician Consortium for Performance Improvement to enhance quality of care and patient safety by taking the lead in developing, testing and maintaining evidence-based clinical performance measures and measurement resources for physicians. The Consortium comprises more than 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies; American Board of Medical Specialties and its member boards; experts in methodology and data collection; AHRQ; and CMS.

Physician Practice Connections

www.ncqa.org

An initiative of the NCQA that rewards and recognizes physician practices for successfully using information technology to improve health care quality.

Quality Enhancement Research Initiative (QUERI)

See Department of Veterans Affairs Quality Enhancement Research Initiative.

Quality Tools

www.qualitytools.ahrq.gov

Sponsored by AHRQ, Quality Tools is an on-line clearinghouse for practical, ready-to-use tools for measuring and improving the quality of health care.

Talking Quality

www.talkingquality.gov

This Web site is designed for people and organizations trying to educate consumers about health care quality and for those who provide consumers with information on the performance of health plans and providers. It is sponsored by the AHRQ, CMS and the Office of Personnel Management.

Acknowledgements

This publication was made possible thanks to the contributions of John Friedman, Lauren Funk, Margaret E. O'Kane, Greg Pawlson, M.D., M.P.H., Sarah Hudson Scholle, Dr. P.H., Sarah Shih, M.P.H., Richard Sorian, Jeff Van Ness, the staff at Burness Communications, especially Mary Darby, and NCQA board members the Honorable David F. Durenberger, Debra Ness, and Ellen Stovall.

APPENDIX 5

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